FAMILY OUTREACH HOME VISITING PROGRAM

REQUEST FOR PROPOSALS

Rhode Island Department of Health
Division of Family Health

June 1, 2006

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SECTION 1: INTRODUCTION

The Rhode Island Department of Health (HEALTH), Division of Family Health will award up to six grants to implement the Family Outreach Program. The purpose of the Family Outreach Program is to improve the health and development of young children and their families through an assessment and referral model of home based outreach, education, referral, and follow-up.

The Scope of Services is described in section five. The Department of Health and the Department of Human Services jointly fund the program. In Fiscal Year 2005, HEALTH provided funding in the amount of $671,860 for this program. Under this RFP, HEALTH anticipates providing this same amount to fund up to six agencies with the potential to increase the contract awards in subsequent years should additional funding become available. Services for children enrolled in Medicaid are funded by billing the Department of Human Services.

The initial project period is expected to begin approximately September 1, 2006 and continue through August 31, 2007. Based on performance and availability of funding, this contract may be renewed for up to one (1) additional 12-month period. Continuation for Year Two of the project period will be based on the Applicants successful completion of Year One project activities and evaluation. A ten percent (10%) verifiable match will be required by the funded agency for each year of funding.

Applicants must meet all of the requirements specified in this RFP. Only one proposal per organization will be accepted. Those organizations that are eligible to apply are public and not-for-profit community-based organizations in good standing with the Federal Government and with a proven record of service in racial and ethnic minority populations.

Representatives of organizations considering applying are strongly encouraged to attend a pre application Technical Workshop on May 30, 2006 at 2:00pm in the Department of Health Auditorium on the lower level. This workshop will provide an overview of program guidelines and answer questions for potential applicants.

SECTION 2: BACKGROUND AND PURPOSE

Overview

The Rhode Island Department of Health (HEALTH) supports developing systems of care with the goal of improving the health and development of families and children. For nearly a century,

public health nurses have been the front line staff for public health programs. In the Division of Family Health (DFH), parent education, family support, and connecting families who have children at risk of poor outcomes with needed services are high priorities. Recent literature indicates that home visiting services can support these priorities by linking families to needed community services, increasing childhood immunization and lead screening rates, and enhancing parenting skills.

Based on the public health nursing model that has existed for over a century, the Division of Family Health has funded and supported a home visiting program for the past 20 years. The current home visiting program, the Family Outreach Program (FOP), focuses on screening and assessing families who have children ages birth to three for developmental risks and referring them to appropriate community services to mediate those risks.

The FOP also functions as an outreach system for health care and developmental services, helping providers reach families when they are aware that the child is at risk for a specific negative outcome, is behind in preventive health services, or has an emergent health concern. The program also serves as a connector in the early childhood system through its capacity to work within communities, creating linkages to local programs and agencies and with state agencies and programs to ensure that families receive services that are accessible and coordinated.

Program Evaluation

Over the past 8 months, the Family Outreach Program has been evaluated in anticipation of this Request for Proposals. The purpose of the evaluation was to build on the strengths of the current program and capitalize on opportunities for improvement. The evaluation included a variety of qualitative and quantitative methods. The combination of methods was designed to provide insight into the current design and function of the program as well as possibilities to expand its scope.

One of the major findings from the program evaluation was the need for more services for the highest risk families. These families have multiple risk factors that compound each other to create very high risk for poor developmental outcomes. Services for these families could include home visiting programs that begin in the prenatal period and continue through the first few years of the child's life. At this time, additional funding is not available for these types of services.

However, HEALTH reserves the right to add additional services to the Family Outreach Program if funding becomes available. For more information on the evaluation, please contact the Family Outreach Program.

Modifications to Current Program

As a result of the recent program evaluation, several modifications have been made to the program design and scope of work. A summary of these modifications is below for applicants' reference. Please consult following sections of the Request for Proposals for detailed information on these changes.

Level 1 Risk Status

- Children identified as "Risk Positive" by the Level 1 screening process will be referred to the Family Outreach Program for a home visit.
- Children identified as "Risk Suspect" and "Risk Negative" referred to the program from community sources may receive visits upon approval by the FOP Program Manager at HEALTH.
- Because the Level 1 screening may identify false negatives, children who are referred to the program due to risks identified by other providers will receive a visit upon approval by the FOP Program Manager at HEALTH.

Multiple Visits and Enhanced Visits

- Children approved for visits from FOP will receive an average of two to three visits for home assessment, parent education and needed referrals.
- When FOP providers determine that additional visits are appropriate, they will request approval from the Program Manager prior to conducting additional visits.

Performance Measures and Reporting

- Agencies will provide monthly updates to HEALTH on a number of performance measures and outcomes, in addition to submission of assessment and service data.
- Agencies will also have the opportunity to meet with the Program Manager twice each year to discuss program performance, success and challenges.

Visit Content

- The following forms will be optional: Family Resource Scale, Family Support Scale, HOME Inventory. Agencies may use the tools if needed, but are not required to use them.

- FOP providers will not be required to provide application assistance to home visit clients. If assistance is needed, referrals can be made to community providers such as Family Resource Counselors.

Level 2 Visits

- Level 2 visits, which include a developmental screening, will occur when the child is 8-10 months of age.

Electronic Data Submission

- Data will be submitted to KIDSNET electronically and all data from required assessment forms must be submitted.
- The timeframe for implementation of electronic data submission to HEALTH will be 6-9 months from the contact start date. At 6 months, KIDSNET will be ready to accept information. After that point, agencies can start to transition their data collection and submission systems. At 9 months, all agencies will be required to submit data electronically to HEALTH.

Problem Statement

The current Request for Proposals (RFP) is being developed in response to a number of concerns:

Early Assessment and Intervention

Research has repeatedly shown that intervention at the earliest possible opportunity provides the greatest benefits for young children. Recent brain development studies substantiate the importance of quality care and healthy environments during early childhood to help children reach their full potential. The home visiting services the Family Outreach Program provides to new mothers and young children takes advantage of a window of opportunity early in life to set them on the best possible trajectory for development. All children in the state are screened at birth, ensuring that the program reaches the entire population, regardless of barriers that might prevent them from accessing other services. The program provides a critical first link to the medical home, assessment, and referrals, which would not otherwise exist, for children and families.

Service Coordination

There are a number of programs administered by state and community agencies that provide a variety of services for families, some of which include home visits. Without a mechanism for coordination, families who meet criteria to receive services from more than one agency may be visited more than once a week and offered the same service(s) from different agencies. This is not only a duplication of services and inefficient use of scarce resources, but also adds to the stress of managing daily life for families that are already at risk. FOP agencies collaborate with other providers to determine which program meets families' needs best and ensure that families connect with services in a timely and coordinated manner.

Outreach

While the Family Outreach Program serves thousands of families annually, there is a significant number of families with identified risk factors that do not receive home visits from the program. Families may be difficult to reach for a variety of reasons, including residential mobility, social isolation, language barriers, cultural differences, lack of understanding or awareness of the program, and concerns about repercussions with DCYF or Immigration. Paradoxically, the hardest to reach families are often those with the highest risk for poor outcomes. As a result, tenacious outreach and follow-up to families referred to the program is a critical component of the Family Outreach Program. FOP agencies must be both creative and diligent in their efforts to reach families and provide services to them.

Data Collection

Data collection is important to the Family Outreach Program on a number of levels, including measuring program performance and developing baseline data on community environments. Ascertaining whether children and their families access and benefit from the services they are eligible for is challenging, but critical to demonstrating the return on investment in the program, and improving program quality. KIDSNET, the Division of Family Health's Children's Preventive Services Information System, allows HEALTH to compile information in the aggregate on the Family Outreach Program performance and other health indicators, helping to ascertain whether or not HEALTH programs are meeting the needs of families in communities. FOP management continuously works with provider agencies to improve tracking of referrals, follow-up and service coordination. The Family Outreach Program also creates a unique opportunity to collect baseline data about the environments in which families live. Because FOP providers work with families in their homes, they have access to critical information about families and their

environments that other providers cannot access. The new Family Assessment under development will capture environmental and housing data that will be an asset to FOP providers as well as other agencies, providers and policymakers.

Culturally Appropriate Services

Rhode Island has a rapidly growing population of families from diverse cultural backgrounds; and as a result, families that are eligible for the FOP speak many languages and represent diverse cultures. HEALTH promotes providing services that are culturally appropriate. All families benefit from materials and services in their primary language delivered by staff from their communities. The use of para-professionals as part of a multidisciplinary team has enhanced the cultural diversity of the FOP in recent years. However, representation from a variety of cultures to meet the needs of families in Rhode Island continues to be a challenge that needs to be met.

Comprehensive, Intensive Services

Many families in Rhode Island need interventions that are broader in scope than the Family Outreach Program. These families have multiple risk factors that compound each other to create very high risk for poor developmental outcomes. Intensive programs that begin prenatally and continue until the child's second or third birthday have been shown to improve developmental outcomes and enhance family success and economic security. The FOP is in a unique position to identify families at high risk, connect with them, and ensure their successful linkage with comprehensive, intensive family support services. If new programs like these are developed on a large scale in Rhode Island, the Family Outreach Program will play a key role in their implementation and may be able to successfully build on their experience with high-risk families and their community connections to provide these services themselves.

Purpose

The purpose of the Family Outreach Program is to improve the health and development of young children and their families through an assessment and referral model of home based outreach, education, referral, and follow-up which:

1. Assesses families with specific risk factors to connect them with needed services and programs so that their children have the potential for the best possible developmental outcomes

2. Assures that children are engaged in regular primary care and connected to a medical home that provides accessible, continuous, comprehensive, family centered, coordinated, and compassionate medical care delivered by professionals who develop a relationship with the child and family
3. Supports parents as care givers though a model that provides an opportunity for families to receive a home assessment, education about community programs, and information about parenting and child development
4. Coordinates assessment, tracking, follow-up, and home visiting services with other community services the family receives
5. Delivers services through community based mechanisms in collaboration with local service providers
6. Provides data on services provided, client characteristics and home environments to HEALTH through the KIDSNET Data System

SECTION 3: ELIGIBILITY TO APPLY

Applications will be accepted from community-based, medical/health, public or private non-profit organizations that demonstrate capacity to deliver the full range of services described in this RFP. Home health and community health agencies are preferred. However, every applicant must demonstrate the capacity to connect children and families to urgent medical and follow up services when appropriate and demonstrate experience in carrying out public health programs. The Department of Health encourages applications from agencies that include broad and inclusive networks of community partners that have experience in family and community outreach, and have experience working with families with young children. All applicants must be in good standing with the federal government. HEALTH will fund up to six agencies for this work.

SECTION 4: ADMINISTRATION INFORMATION

Projected Timetable:

June 13, 2006 @ 10:00 am	Technical Assistance Workshop RI Department of Health, Cannon Building 3 Capitol Hill, Beck Conference Room (lower level) Providence, RI 02908
July 7, 2006	Proposals due at HEALTH by 4:00 p.m.
September 1, 2006	Approximate Start Date of Contract

Submission Procedures

The deadline for submission of proposals is 4:00pm on June 30, 2006. No applications will be accepted after this date and time. Proposals sent by mail are sent at your own risk. Applicants are urged to hand deliver their proposals that will be date stamped upon receipt. Faxed applications will not be accepted.

All proposals must be typed in English and double-spaced. Maximum length is 35 pages. Appendices may be used for relevant supporting information and are not counted in the page limit but should not exceed 20 pages. Proposals will be stored in a locked file cabinet as they are received and shall be protected from disclosure until they are opened. One original and four (4) copies must be delivered to:

Blythe Berger
Division of Family Health
Rhode Island Department of Health
3 Capitol Hill, Room 302
Providence, RI 02908

Selection Process

The Technical Review Committee, comprised of Rhode Island State Employees representing the Department of Health, Division of Family Health and the Department of Human Services will review eligible proposals. Proposals will be scored and ranked according to the attached Evaluation Score Sheet and the overall soundness of the proposed budget and accompanying budget narrative. Maximum possible score is 100 points and applicants scoring below 60 points on the technical review will not be considered. Those proposals ranked highest by the Review Committee may be asked to make an oral presentation or provide written clarification prior to final recommendation for award.

Right to Award, Reject, or Negotiate

The Rhode Island Department of Health reserves the right to:

- Award a contract with or without further discussion of proposals submitted.
- Reject any and all proposals submitted.
- Request an oral presentation of the proposals to clarify the proposal and to assure sure mutual understanding.

- Arrange an on-site visit prior to an award being made to determine the applicant's ability to meet the terms and conditions of the RFP.
- Establish a later effective date in the contract if circumstances are such that it is in the Rhode Island Department of Health's best interest to delay it.
- Enhance and expand the activities within the same scope of services depending on the availability of funding.

SECTION 5: SCOPE OF SERVICES

Program Objectives

The following are objectives of an integrated public health, risk response, follow-up and home visiting program:

- Increase early identification of risks to healthy development and connect children and families with resources to reduce the risks
- Improve parent knowledge about child development and community resources and support families in fostering healthy development
- Improve developmental outcomes for children
- Assure that young children are involved with a medical home
- Increase the number of families who accept visits from the program, in particular, those families who may have several of the risk factors identified during a newborn screening or as a child develops
- Assure that the Family Outreach Program is connected to and collaborates with local community agencies and expand referral networks
- Assure that every infant receives appropriate follow-up for hearing screening, metabolic screening, and developmental risk assessment results
- Promote breastfeeding and connect new mothers with breastfeeding resources
- Promote age-appropriate immunization and lead-screening and connect families with medical resources if necessary
- Reduce exposure to lead and other environmental hazards, and ensure appropriate medical and environmental follow-up for children identified with high blood lead levels

Program Design and Requirements

Experience with the FOP program over the past five years has demonstrated several key points:

- Families referred to the Family Outreach Program often have multiple risks and are difficult to make contact with, which necessitates creative and persistent outreach strategies
- Clearly defined geographic regions ensure that families and service providers are linked to community services and referrals are coordinated
- Multi-disciplinary teams provide access to an array of services and improve cultural responsiveness

Agencies responding to this RFP will be expected to demonstrate capacity and knowledge of working with a public health model of home visiting, experience in community outreach, and coordination of health and community services. Agencies must also demonstrate the capacity to ensure urgent direct health care services can be provided when necessary either through linkage or collaboration with other health care providers. Agencies responding to this RFP will be expected to develop teams of individuals that will serve a defined geographic region. An agency can apply to serve more than one region if the agency can demonstrate its capacity to do so. Each team will be required to have at minimum, at least one Registered Nurse with pediatric health care and public health experience, a social worker with experience working with families with young children, and a para-professional with experience linking families with community resources. Teams that serve contiguous regions will be expected to coordinate with each other. HEALTH will facilitate this coordination if necessary. HEALTH will fund up to 6 agencies to manage the FOP over the next two years.

Scope of Work

By design, this initiative coordinates outreach for many of the HEALTH programs which benefit families and children. Following is a description of the minimum services contracted agencies are required to deliver under this RFP.

A. FOP Home Visits

Initial Visits: Level 1 Referrals

All infants born in Rhode Island are screened for developmental risk factors at the birthing hospital. This is known as the Level I screening. At present, Level 1 risk criteria include parent demographics, parent and child characteristics, and certain medical conditions (see appendix A for specific risk criteria). HEALTH reserves the right to reevaluate and change referral criteria. Infants whose screening deems them eligible for the Family Outreach Program will be referred to the appropriate FOP agency. Agencies must respond to referrals by contacting and

attempting to visit all families within 7 calendar days of referral, unless the family is a priority referral, in which case the response should occur within 24 hours of the referral.

HEALTH recognizes the need to tailor home visits. In cases in which the family has many known social service issues that necessitate the assistance beyond what a nurse can provide, a social worker may make the initial visit. Other members of the multidisciplinary team may participate in the first visit when necessary or appropriate.

The Initial Home Visit will at the minimum include:

a. Family Assessment: using the Family Assessment Tool which captures health, developmental, psychosocial, and environmental risks in the home
b. Child Developmental Assessment: using the Infant Assessment
c. Family Support Plan: developed in collaboration with the family and the primary care provider, which includes referral to appropriate programs. A family support plan will identify and plan for the coordination and management of significant child and family health, developmental, and psychosocial risks. The primary care provider, appropriate community agencies, and future home visits will address specific risks. Progress will be shared with parents and the primary care provider.
d. Referrals: Once the family's needs are determined, referrals to the appropriate programs should be made and documented
e. Education on and modeling of infant care: educate the family about aspects of infant care, for example, providing education around: feeding positioning, bathing, sleeping positioning
f. Educational materials: materials should be offered to the family on appropriate topics including child safety, nutrition, development and community resources, depending on the child's age and family's needs

Initial Home Visits: Other Referral Source

Families with risk factors for poor developmental outcomes are sometimes referred to FOP agencies by health care providers and other community service providers. Upon approval, home visits may be conducted for families with children under age three who are referred to FOP agencies from these other sources. The agency must contact the FOP Program Manager at HEALTH and provide a brief justification for the services using the form provided. The form includes information on risk factors and services to be provided. Once HEALTH approves the

provision of services, the agency may visit the family. This will allow HEALTH to monitor the number of visits and provide information on gaps in services. Referrals from HEALTH programs such as Lead and Immunization do not require approval.

HEALTH recognizes the need to tailor home visits. In cases in which the family has many known social service issues that necessitate the assistance beyond what a nurse can provide, a social worker may make the initial visit. Other members of the multidisciplinary team may participate in the first visit when necessary or appropriate.

Home visits should be tailored to meet the family's needs, but initial home visits will at the minimum include:

a. Family Assessment: using the Family Assessment Tool which captures health, developmental, psychosocial, and environmental risks in the home
b. Child Assessment: assesses the child's developmental status using either the Infant Assessment or Ages and Stages depending on the age of the child
c. Family Support Plan: developed in collaboration with the family and the primary care provider, which includes referral to appropriate programs. A family support plan will identify and plan for the coordination and management of significant child and family health, developmental, and psychosocial risks. The primary care provider, appropriate community agencies, and future home visits will address specific risks. Progress will be shared with parents and the primary care provider.
d. Referrals: Once the family's needs are determined, referrals to the appropriate programs should be made and documented
e. Educational materials: materials should be offered to the family on child safety, nutrition, development and community resources, depending on the child's age and family's needs

Level 2 Visits

Families are offered a Level 2 developmental screening home visit if they were referred to FOP through Level 1 screening, or if they are approved for visits after referral from another source and a Level 2 visit is indicated. These visits should occur when the child is between 8 and 10 months of age. If the first visit to a family is when the child is 8-10 months of age the visit should also cover all of the criteria listed for an initial home visit. Based on the results of the Level 2 screening, appropriate referrals will be made based on needs identified in the screening.

Home visits should be tailored to meet the family's needs, but a Level 2 visit will include at minimum:

a. Family Assessment: using the Family Assessment Tool which captures health, developmental, psychosocial, and environmental risks in the home
b. Child Developmental Assessment: using the Ages and Stages Questionnaire
c. Family Support Plan: develop a family support plan if one does not exist or review and revise existing family support plans
d. Referrals: Once the family's needs are determined, referrals to the appropriate programs should be made and documented
e. Educational materials: materials should be offered to the family on child safety, nutrition, development and community resources, depending on the child's age and family's needs

Follow-up Visits

Follow-up visits for families should be conducted as needed. HEALTH recognizes that follow-up visits may be necessary to address families with multiple risks and issues or may be appropriate if all material is not covered during the initial visit.

However, HEALTH recognizes that the Family Outreach Program provides services on an individualized basis and that families with complex needs may need more visits. If a family needs more than three visits, the agency providing services must contact the FOP Program Manager at HEALTH and provide a brief justification for the continuation of services using the form provided. The form includes information on risk factors, services to be provided, and gaps in the service system that necessitate continued service delivery. Once HEALTH approves the continuation of services, the agency may visit the family. This will allow HEALTH to monitor the number of visits and collect information on gaps in services.

CAPTA Visits

The Family Outreach Program has recently entered into a partnership with the RI Department of Children, Youth and Families (DCYF). The partnership helps DCYF fulfill its mandate to screen children under age 3 who have experienced abuse or neglect for developmental delays. With facilitation by an FOP staff person working with DCYF, FOP agencies will receive referrals to screen children in their region. FOP providers will conduct a home visit and administer the Ages

and Stages Questionnaire. Children may be in foster care or with their families at the time of the screening. FOP providers will then make a referral to Early Intervention or other services as determined by assessment.

B. Coordination with Specific Programs and Providers

Rhode Island has a number of different programs and initiatives that support the healthy development of children and families. Some programs meet very specific needs while some are more general. The following is a brief description of these programs. Agencies applying in response to this RFP will be expected to submit a plan, as part of their application, for coordinating with each of the following programs or providers. The plan should describe how families will be referred to these programs and providers and how agencies will ensure that families connect with the agencies and engage in services.

Department of Human Services

Agencies will be expected to be familiar with Department of Human Services (DHS) field offices and the services that can be received or coordinated there. These offices are the entrance point for RIte Care as well as other DHS services. Agencies will be expected to refer families to appropriate services, including DHS Field Offices, for assistance in completing initial applications and recertification applications for Medicaid, RIte Care, FIP, Food Stamps, and child care subsidies.

Medical Homes

A medical home is not a building, house, or hospital, but an approach to providing comprehensive primary care to children. The American Academy of Pediatrics defines a medical home as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. In a medical home, a pediatric clinician works in partnership with the patient and family to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child/youth and family.

Medical homes are an important component of an effective early childhood system and the development of medical homes for all children is a priority for HEALTH. Agencies will be

expected to be familiar with pediatric primary and specialty care provides in their area and to develop and maintain relationships with providers. These relationships will assist agencies in ensuring that all children who receive home visits are connected with a medical home and are receiving the coordinated services they need. If a child does not have a medical home, the visiting agency will be responsible for referring the family to an appropriate provider and following up on that referral.

CEDARRs

The agency awarded the contract for the Family Outreach Program in each region will be expected to develop a plan for linkage and coordination with CEDARR Family Centers. These centers are an interdepartmental initiative led by the Department of Human Services to provide a family centered system of care for children with special health care needs (CSHCN), who are Medicaid eligible. CEDARR centers are comprehensive sources of information and clinical expertise, designed to assess family needs and connect families with community programs and supports. FOP can provide valuable information to enhance the work of CEDARRS, so it is important for the programs to work together to provide reinforcement and coordination. It is expected that the FOP will make referrals to CEDARR centers when appropriate.

Early Intervention

An important role of the Family Outreach Program is to create access and support linkages to Early Intervention (EI) Services. The FOP serves as an important avenue for identification of children who may be eligible for the EI program. Three primary points of referral to EI from the FOP are, as a result of conditions identified through the Level I screening, as a result of concerns identified though Level 2 developmental screening, and as a result of concerns identified in CAPTA screenings. In addition, EI providers may make a referral to the FOP for a Level 2 screening in order to determine probable eligibility for EI. This is a cost-effective way to assess a child's risk for developmental delay. When appropriate, FOP will refer children to EI for further screening and assessment.

FOP agencies must specify the type of professional who will be trained to conduct Level 2 developmental assessments. If a child is not eligible at birth for EI services, the agency's proposed plan for connection with EI should specify how the Family Outreach Program staff will be trained to recognize when a child might benefit from EI services and should be referred.

It is expected that applicants will demonstrate understanding of EI eligibility criteria, develop a relationship with their local EI provider, and have knowledge of other programs for children under age three who do not qualify for EI. The EI program provides statewide access to all providers and families can choose where they will receive services. Therefore, the agencies awarded the FOP contract will need to be familiar with all of the EI sites in the state to ensure that families are offered a choice when their children are referred to EI.

KIDSNET

KIDSNET is Rhode Island's confidential, computerized child health information system. KIDSNET serves families, pediatric providers, and public health programs including the Immunization Program, WIC, FOP and Early Intervention. The purpose of KIDSNET is to help make sure that all children in Rhode Island are as healthy as possible by getting the right health screening and preventive care at the right time. KIDSNET has several components including:

1) An electronic automated, real-time tracking and follow-up system which links several HEALTH programs (Universal Newborn Developmental Level 1 Screening, Family Outreach Program, Immunization, Newborn Hearing Assessment, Lead, Metabolic/Hemoglobinopathy Screening, Early Intervention and WIC
2) Access for physicians and other authorized public health programs to screening test results, program enrollment, and other selected public health information such as immunization records
3) Systematic coordination of follow-up response for all children in need of public health services.

All children born in Rhode Island on or after January 1, 1997 are in the KIDSNET system. More specifically, KIDSNET creates a child profile allowing HEALTH programs and primary care providers to obtain information online about preventive public health services received by the family. Maternal and Child Health programs at HEALTH can share program specific information as well, based on need to know and confidentiality procedures and policies. Together with existing tracking databases, KIDSNET will indicate all of the public health follow-up services needed by each child under six years old in Rhode Island.

KIDSNET is a valuable tool for FOP and FOP is a critical component of KIDSNET. Respondents to this RFP will be expected to submit data collected at every home visit on: reasons for referral,

results of screenings/assessments, referrals made, and the outcomes of those referrals. Agencies must demonstrate the capacity to enter this data directly into the FOP module of KIDSNET as soon as possible, but not later than 7 days after the visit. They must also demonstrate the capacity to use KIDSNET to help locate families, the capacity to coordinate closely with the KIDSNET systems, and the capacity for data sharing and information transfer. HEALTH will train staff at the FOP agencies to use KIDSNET, but the agency must demonstrate capacity to enter data into the KIDSNET system in a timely manner, and for information sharing and transfer. For more information on data and technical requirements, see Section F. Data and Technology, page 23.

Newborn Bloodspot Screening

If a family has a child who is at risk for a metabolic, endocrine, or blood disorder or other condition identified though the newborn bloodspot screening, the Family Outreach Program may be asked to assist in locating the family within 24 hours and contacting them to bring the child into care.

Rhode Island Hearing Assessment Program (RIHAP)

The Family Outreach Program will provide appropriate risk response for infants referred by RIHAP who were not screened at birth and children who need to be re-screened. Referrals must be followed-up within 7 days. Home visitors will give families who have not completed the screening process information about the importance of hearing testing and facilitate scheduling an appointment during the home visit.

When all other outreach efforts have been unsuccessful by RIHAP, FOP will conduct a home visit to provide family support, developmental screening, and follow-up for infants awaiting audiological follow-up testing.

Immunization

The Family Outreach Program is designed to complement and reinforce the programs and initiatives of the Division of Family Health. In order to support the goal of timely and appropriate immunization for all Rhode Island children, FOP providers will discuss and promote immunization during their visits. This will be accomplished through the distribution of immunization information as part of the home assessment. FOP providers will also assure that all children have a medical home and will review the next well child check with the parent or

guardian and ensure the appointment has been made. In order to bring children up to date with the Rhode Island immunization schedule, FOP providers will assist in arranging appointments with the child's primary care provider. When families do no have a medical home, providers will educate parents about the availability of free clinics at Hasbro and St. Joseph's hospital for urgent immunization needs. FOP providers will check the immunization status of siblings if they are present in the household and provide other immunization outreach, education, and other activities, as required.

Providers will also educate caregivers about the importance of immunization against hepatitis B. If the mother's hepatitis B surface antigen status is positive, FOP providers will work with the child's medical home to bring the child into compliance with an accelerated hepatitis B schedule.

Lead Poisoning Prevention

The Family Outreach Program is also designed to compliment the Division of Family Health's lead poisoning prevention program. In order to ensure that children who have or are at risk for lead poisoning reduce their risk, FOP providers will:

1. Evaluate the homes of all families that receive FOP home visits for lead hazards and provide parent education about reducing hazards.

2. Conduct *preventive* lead education home visits for all children with confirmed lead levels of 15-19 μg/dL. The lead education home visit will include:
    - Verify the family's address and/or use other resources/methods to locate the family
    - Visually inspect the home and educate the family about areas that are possible lead hazards
    - Discuss the possibility of lead hazards in other locations where children spend a great deal of time (home child care provider, relatives' homes, etc.)
    - Demonstrate to the family how to clean to avoid lead contamination using cleaning supplies (duct tape and TSP) and provide the family with samples of both products
    - Distribute language appropriate educational materials to all families, as well as incentives when available
    - Recommend screening of all children under six in the household following RI Lead Screening Guidelines

- Encourage the family to use the Family Health Information Line for further information on health topics for children
- Conduct a follow up visit to ensure that steps have been taken to reduce lead exposure.

3. Conduct home visits for all families with "significantly lead poisoned" children (currently, equal to or greater than 20 μg/dL) who reside in the agency's geographic catchment area and are referred by the RI Childhood Lead Poisoning Prevention Program. The purpose of the visit is to offer the same services that children with confirmed lead levels of 15 to 19 μg/dL receive, described above, and in addition:
   - Provide a Level 2 developmental screening for children under the age of three
   - Provide parent education and referrals to bring all children in the household into compliance with lead screening and treatment protocols
   - Assist the inspector (private contractor) in scheduling the environmental inspection of the home and educate the family about the importance of accepting the inspection
   - Provide additional information/resources about where families can get assistance or funding for lead renovations or lead hazard reduction work
   - Complete visual assessment forms and other paperwork as required, indicating status/outcomes of the effort made. Submit all paperwork to the Lead Program no later than 30 days after referral is received

4. Assist in locating families who are identified by HEALTH and Managed Care Plans who have children with no evidence of lead screening and have not had access to care through a primary care provider. This assistance includes:
   - Filling out the appropriate assessment form, provided for this purpose
   - Providing aggregate reports of efforts and/or participating in relevant meetings when notified by HEALTH

5. Conduct other outreach education and activities as may be needed.

<u>WIC</u>

With any home visit to a pregnant woman or family with children under the age of 5, the home visitor will discuss family food needs and the WIC program, determine whether the family may be eligible for the program, and provide contact information for the local WIC agency. If a family

drops out of the WIC program, a referral will be made to the appropriate home visiting agency. The FOP will attempt to determine why the family is not participating and reestablish the connection with WIC when possible. FOP agencies are expected to develop relationships with local WIC agencies to facilitate the referral process.

C. Community Coordination

Within many communities in Rhode Island there are networks of community agencies that meet on a regular basis to address issues of coordination, integration of services, and transition between programs. FOP agencies will be expected to participate in existing community networks or establish community networks in regions where one does not already exist. Networks should, at the minimum, include membership from the local pediatric community, other agencies that provide home visits, social service agencies, local DCYF offices, Early Intervention, local CEDARR family centers, COZ Family Centers, and child care programs. If these partners do not currently participate in the network, FOP agencies are expected to develop relationships with them and encourage them to become involved in the network. Other partners maybe very valuable and should be included at the discretion of the agency.

Through involvement in community coalitions, FOP agencies will:

- Educate communities about the FOP
- Develop strategies to conduct outreach to families who are difficult to locate
- Establish referral and follow-up protocols with community agencies for families who might benefit from referral to the FOP
- Engage families that were referred to the program but refused an initial home visit or could not be located
- Identify families who were not eligible for the FOP as a result of Level I screening, but are identified at a later point as having risk factors which might result in poor child outcomes
- Identify gaps and limitations in services and enrich FOP knowledge/access to community agency resources

D. Outreach

As part of their proposals, agencies will submit an outreach plan that details the strategies they will use to reach out to families referred to the program, with a special emphasis on families with multiple risk factors. The plan should include a protocol for contacting a family for the first time, including the type of professional that will make the initial contact and protocol for subsequent

contact if the first attempt is not successful. The plan should also detail how the agency plans to meet the needs of families from different cultural backgrounds, who speak different languages and who are highly mobile. Applicants are also expected to develop and submit plans for linking with, coordinating with, and communicating with outreach partners, including the pediatric community and the child care community.

OMB Directive 15 identifies racial and ethnic minority populations as African Americans, Native Americans, Latinos/Hispanics, and Asian Americans. Applications should include the following:

- The projected number of racial/ethnic minority families to be reached by the project, based on demographic data for the region to be served
- Description of the agency's access and/or proposed outreach to the population described above
- Description of how racial and ethnic composition of the target population is reflected in the administrative and service delivery staff

If other groups are also target populations for your program, please provide a paragraph explaining the reasons why these other populations are an appropriate target group for your program and a description of other criteria that define the target population.

E. Training

Each agency will develop and submit a training plan for their agency staff with the application. Required components include: orientation for new staff, personal safety, assessment tools and measures, data entry into HEALTH data systems, communication with families, and cultural competence. HEALTH will provide training as needed on technical aspects of data entry and submission. FOP providers will be required to participate in all FOP trainings sponsored by HEALTH.

F. Data and Technology

In order to improve the timeliness, completeness, and reliability of home visiting data in KIDSNET, HEALTH is currently designing specifications for electronic data exchange between home visiting agencies and KIDSNET. HEALTH plans to begin data exchange with agencies within six months after the commencement of the new contracts. All agencies will be required to submit program data electronically within nine months after the commencement of the new contracts. HEALTH has funding to provide limited technical assistance to agencies in

developing the technical specifications for the required electronic forms and in integrating the specifications into their existing electronic systems.

KIDSNET currently conducts data exchange with a variety of systems, including Vital Records, WIC, Hearing Assessment, Lead, and systems at many individual immunization provider offices. Most providers exchange data with KIDSNET based on the transmission of batch files to HEALTH's Secure Web File Repository (kidsnet.health.ri.gov/wfr). KIDSNET is also currently developing an interface to support real-time and batch data exchange of demographic and immunization data with provider Electronic Medical Record (EMR) systems. For FOP data exchange, HEALTH will develop a message transport and message type specification that best meets national standards while being suitable to the capabilities of the agencies' systems. Business rules will be developed regarding the frequency of data transmission, how to handle errors in data exchange, and precedence of address and telephone data from an agency versus data already in KIDSNET. Information collected through this RFP process will contribute to the development of these specifications. Options under consideration include:

- a custom flat-file data format specification combined with periodic batch uploads to the Web File Repository
- a custom-developed XML schema implemented as part of a Web Service specification
- an HL7 version 3 implementation combined with CDC's PHIN-MS transport.

Agencies must indicate in their response whether they utilize or have plans to utilize a homecare information system, such as Cerner BeyondNow, McKesson Horizon, Meditech Homecare, Patient Care Technologies, Misys Homecare, 3M Health Information Systems, Procura, CareFacts HIS, Fujitsu Homecare, Golden Rule Oasis, Homecare Telemedicine, or Home Infusion. Agencies should also indicate whether they are currently conducting electronic data exchange between their information system and any other data system, and describe the technical specifications of the exchange. Indicate, for example, the type of message transport (such as CDC's PHIN-MS, web services, FTP, etc.), the type of message format (such as HL7 version 2 or 3, a custom XML schema or a flat-file format), and the frequency of exchange.

Agencies must indicate their degree of readiness to participate in electronic data exchange with KIDSNET, what changes they would need to make to their data systems, and the proposed timeframe for such changes. The scope of the data model will include a Level 1 ID number or KIDSNET ID number, demographic information, and all fields included in required assessments

and forms (copies available on request). Agencies proposing to participate in electronic data exchange with KIDSNET should indicate whether they are currently collecting such data in their information system, and if not how they would integrate additional screens and forms within their applications to collect the data.

While the FOP data exchange specifications are developed and the appropriate enhancements are implemented in KIDSNET, direct data entry into KIDSNET will continue to be required of all agencies as described above. For agencies that do not utilize a homecare information system or do not have the capacity to participate in electronic data exchange, direct data entry into KIDSNET will remain an alternative method of providing the appropriate home visiting data to KIDSNET as required by the contract.

G. Evaluation

The overarching goals of the Division of Family Health (DFH) are to improve birth outcomes, to support optimal child health and child development, and to promote good adult health and effective parenting. The specific objectives most relevant to the Family Outreach contracts are breastfeeding, timely immunization and lead screening, prompt referrals to Early Intervention, and connection to a medical home. Agencies awarded the FOP contract will be required to meet with DFH staff to monitor appropriate outcome measures for the improvement of these measures among prenatal and pediatric populations. These are core Family Health indicators, and so these performance measures are tracked in the entire population, as well as among children and families seen in specific Family Health programs. Family Outreach Program contractors will be encouraged to set additional outcome measures to address specific concerns for these target populations in their regions, working with their regional networks, and with the assistance of Family Health staff.

Evaluation is a core requirement of any health contract, and home visiting teams will be expected to participate in a variety of Division Family Health programs and projects, each with their own evaluation requirements. The basic evaluation requirements are careful, prompt documentation of home visiting and other community activities associated with this contract, and also full and flexible participation with other community providers and DFH staff in the documentation and analysis of needs and services. FOP agencies will document all activities related to this initiative and make them available to HEALTH when requested for purposes of monitoring or quality assurance

Specifically, all home visits and other community services provided under this contract must be fully documented using required instruments and retained in the agencies' clinical records for the family. FOP visit, referral and assessment data must also be promptly recorded and entered into the Family Outreach Program database in KIDSNET. Agency staff responsible for this contract will also be expected to participate fully in management and program evaluation meetings with the Division of Family Health.

Providers will submit the following information on a monthly basis in the format specified by HEALTH:

- Level 1 Capture Rate
- Level 2 Capture Rate
- Visit Timeliness Rate
- Multidisciplinary Team Usage
- KIDSNET report usage

In addition, the following information should be documented and available to HEALTH staff:

- Outreach Protocol Adherence
- Multiple Language Protocol Adherence
- Referral Outcomes
- Outreach efforts/new outreach strategies
- Community partnership development and membership
- New Partnerships/linkages within communities (e.g. pediatric practice)

Providers will be required to work with HEALTH during the first six months of the contract to develop a method for measuring clients' satisfaction on an ongoing basis. The method will need to capture responses from a cross-section of clients served that represents various languages, ethnicities, and neighborhoods. Standardized client satisfaction tools and agency-specific measures will be considered during the development process.

FOP providers will meet at least twice each year with the Program Manager to discuss program performance, success and challenges. The qualitative and quantitative measures described above will be included. Efforts toward continuous quality improvement, both at the FOP agency and at DFH will be discussed.

Eligibility to Apply

Applications will be accepted from community-based, medical/health, public or private non-profit organizations that demonstrate capacity to deliver the full range of services described in this RFP. Home health and community health agencies are preferred. However, every applicant must demonstrate the capacity to connect children and families to urgent medical and follow up services when appropriate and demonstrate experience in carrying out public health programs. The Department of Health encourages applications from agencies that include broad and inclusive networks of community partners that have experience in family and community outreach, and have experience working with families with young children. All applicants must be in good standing with the federal government. HEALTH will fund up to six agencies for this work.

Service Area

This initiative seeks to provide services to all children in Rhode Island who are eligible. It also recognizes the enhanced service coordination and program linkages that are created by regionalized services. The Department of Health will accept proposals to serve one or more of the following regions:

- **Bristol County:** Barrington, Bristol, Warren
- **Kent County:** Coventry, East Greenwich, Warwick, West Greenwich, West Warwick
- **Newport County:** Jamestown, Little Compton, Middletown, Newport, Portsmouth, Tiverton
- **Metropolitan Providence County:** Central Falls Cranston, East Providence, Johnston, North Providence, Pawtucket, Providence
- **Northern Providence County:** Burrillville, Cumberland, Foster, Glocester, Lincoln, North Smithfield, Scituate, Smithfield, Woonsocket
- **Washington County:** Charlestown, Exeter, Hopkinton, Narragansett, New Shoreham, North Kingstown, Richmond, South Kingstown, Westerly

An agency does not need to be located within the region it proposes to serve, however community coordination will be expected and will be factored into the scoring process. In addition, an agency must demonstrate the capacity to provide services in the region it is proposing to serve through examples of existing community linkages and prior experience

working in the proposed areas. Agencies are required to serve all referred families in all neighborhoods within the region they propose to serve. Once an award is made, HEALTH reserves the right to negotiate with awarded agencies to assure that all six regions are being covered and families have access to services in their local community. HEALTH may select agencies based on their ability to provide services in the proposed areas. Agencies will be expected to cooperate to define services areas and communities in collaboration with HEALTH.

Documentation and Deliverables

- Monthly performance measures
- Rosters and minutes from Community Partnership meetings
- Daily data entry into KIDSNET, including visit information and assessment information

Role of Agency

Applicants must demonstrate the capacity to deliver services that are culturally competent, family centered and coordinated with other community resources. In addition, applicants must have appropriate plans for staffing and supervision. Applicants must demonstrate their commitment to creative and persistent outreach and follow-up to ensure that all children and families referred to them will benefit from the programs to which they are entitled.

Staffing

Home Visiting teams must be multidisciplinary and include a Registered Nurse, Social Worker, and a para-professional. Nurses must have at least an RN credential and social workers are required to have an MSW, or a BSW if an individual with an MSW supervises them. The qualifications for para-professional include a GED or High School diploma or equivalent experience working with families and children, the maturity and ability to manage situations in which abuse or neglect may be present, CANTS clearance, and 30 hours of training prior to assignment. All staff must have training and/or experience working with families with young children.

Billing

HEALTH must meet its obligation to monitor and assure that the requirements of the contracts awarded under this RFP are met. To that end, the following reporting and billing criteria have been established:

- Services rendered to children enrolled in RIte Care or other Medicaid programs will be billed to Medicaid through EDS
- Service rendered to children not enrolled in RIte Care or other Medicaid programs will be billed to HEALTH
- Agencies will bill Medicaid and HEALTH monthly for services rendered
- Agencies will provide documentation of all billing to HEALTH
- Agencies will demonstrate ability to maximize Medicaid reimbursement collection and reconcile Medicaid billings

Funding

The FOP is a Fee for Service program based on the following rates:

Nursing Visit	$99.00/visit
Social Worker	$84.00/visit
Para-professional	$70.00/visit

SECTION 6: REQUIRED COMPONENTS OF THE PROPOSAL

This section includes instructions for preparing the proposal. Applicants are cautioned to review the instructions carefully. Failure to comply with these instructions fully may result in disqualification.

The proposal must include the following:

1. A transmittal letter, signed by an individual authorized to sign contracts for the applicant agency, which is the agency submitting the proposal, and identify the contact person for communication regarding the proposal. Please include the agency's FEIN number.
2. Copies of the IRS letter granting 501 (c)(3) non-profit status to the applicant agency and any proposed sub-contractors.
3. The Technical Proposal
4. The Cost Proposal
5. A Business Plan with narrative
6. Letter of Support from key partners in the proposed service areas
7. Structure and organization of agency, including the ethnicity of current staff and the Board of Directors
8. Curriculum Vitae of key personnel

The technical proposal should respond to each specific area outlined below. Applicants are encouraged to be as specific as possible and to substantiate responses with documentation whenever possible.

The technical proposal must include:

1. Agency Information: This section must describe the applicant agency. If other agencies are listed as collaborators or linkages, these agencies should also be described. It should demonstrate the agency's capacity to respond to referrals in a timely manner, including a staffing plan. This staffing plan should include descriptions of the following:
   - Existing staff who will fill proposed positions or new proposed staff members and experience and qualifications for both
   - The responsibilities of each staff member for the home visiting activities
   - plan for staff development, supervision, communication, and reporting formats.

   In addition the plan must describe the agency's capacity and protocol to contact families and schedule visits, with a detailed description of content for Level 1 visits, Level 2 visits, and visits to families who are referred from other sources. The plan should detail the staff person who will conduct the visits for both Level l and Level 2 visits and the credentials of the individual who will assess the child at both visits. A plan for how referrals will be followed up and a plan for how the agency will coordinate with DOH and DHS programs should also be included.

2. Service Coordination: This section must describe the applicant agency's previous experience and future plans for coordination with each of the specific programs described in the scope of work.

3. Community Coordination: The agency submitting the proposal must be the lead applicant; however a description of proposed community linkages, including whether an agency plans to join an existing community consortium or create a new one must be included. A description or attached list of existing or potential community collaborators should be included. Briefly describe how the agency plans to use community linkages to identify and serve families.

4. Outreach Plan: This section must demonstrate a plan for outreach activities, including the type of activities, person responsible for coordinating outreach, plan for families who are difficult to reach, at what point and for what reasons outreach is discontinued, and how outreach actives will be coordinated with other programs described in this RFP.

5. Training Plan. This must include what staff will be required to participate in specific training, a list of the topics on which training will be offered, how often training will be offered, and who will be responsible for coordinating it. The plan should also specify how the training would take advantage of HEALTH resources.

6. Evaluation Plan: This section must describe how measures of evaluation, including performance measures, outcome measures and quality assurance measures, will be collected and provided to HEALTH, who will participate in providing them, and how the agency will pursue continuous quality improvement.

7. Service Area Description: This section must include the proposed service area(s), current linkages within the community, knowledge of the characteristics of the community, how new linkages will be made, and how the agency will ensure community coordination if the agency is not located within the community. The agency must include a description of the challenges and coordination objectives for the region they are proposing to serve.

8. Technology Plan: This section must indicate whether the agency utilizes or has plans to utilize a homecare information system and whether they are currently conducting electronic data exchange between their information system and any other data system. It should also indicate that agencies are willing and able to participate in electronic data exchange with KIDSNET, what enhancements would be required to their data systems, and the proposed timeframe for such enhancements.

9. Business Plan and Narrative (not to exceed 5 pages): This component should consist of two parts: a budget summary (see attached Appendix C) which lists resources and expenses and a narrative which describes each budget line item entry. The budget narrative must also include the personnel, hourly wage, and percentage of time each staff member will devote to the project. The budget must show a 10% verifiable match (required contribution) by the

applicant agency. Please submit a business plan for a 12-month period that is sufficient to accomplish the project goals.

SECTION 7: REPORTING REQUIREMENTS

Successful applicants will be required to complete all deliverables as required in the Scope of Work and submit monthly invoices by the 10th of each month following the delivery of services and accompanied by appropriate documentation to monthly reporting requirements.

SECTION 8: BUDGET AND BUDGET NARRATIVE

The applicant is required to submit a complete twelve-month program budget with justification narrative that will cover all estimated financial needs. The applicant is expected to detail the annual amount of anticipated revenue generated to offset the documented expenses and to cover the costs of the program. The business plan should also breakdown proposed revenues and expenses by payment source (e.g. Medicaid, HEALTH funds, or other).

The total program budget will allow the Department of Health to review the applicants' total estimated cost for delivering services under this RFP. The total program budget should include the projected caseload and projected number of visits by personnel type (Nurse, Social Worker, Paraprofessional) and by funding type, (HEALTH or Medicaid) including Medicaid denials. A 10% verifiable agency match is required, and agencies that can demonstrate additional funding and services will be given priority. The budget narrative should be as detailed as possible. If the financial plan is not acceptable, HEALTH reserves the right to request a revised financial plan.

EVALUATION SCORE SHEET

NOTE: Proposals must receive a score of at least 60 points on the technical review to be considered for an award.

1. *Agency Capacity to Carry out program* .....0-50____

- Agency has provided adequate evidence of capacity to respond to all referrals within the specified time period
- Agency has provided detailed and adequate description of the protocol for Initial Visits, Level 2 visits, follow up visits, and CAPTA visits including contact mechanism, staff who will conduct visits, and how referrals will be made
- Agency has adequate experience assisting families to develop a support plan including linkage to appropriate services within the specified time period, and describes plans for involving families in assessing their own needs and creating family support plans
- Applicant has proposed detailed plans for adequate coordination with DHS and DOH Programs
- Staffing plan includes a variety of professionals to create a multi-disciplinary team with the appropriate credentials.
- Agency has am adequate management plan for staffing project, which includes appropriate supervision
- Agency has submitted adequate training plan for orienting new staff to the program and ongoing professional development, which has appropriate content, including components for cultural competence, personal safety, assessment tools and measures and communication with families
- Agency has demonstrated capacity to send staff to any HEALTH sponsored training while still conducting program activities
- Agency has provided Curriculum Vitae of key personnel
- Agency has proposed adequate plan for collection and reporting of required performance measures as well as information on protocol adherence, partnerships and client satisfaction.
- Applicant has described plan for assessment of progress toward outcomes and continuous quality improvement
- Agency has demonstrated adequate capacity to serve proposed area, including current linkages to community agencies and program, and how additional linkages will be made.
- Agency adequately describes how the areas will be served if the agency is not located within the proposed service area
- Agency provides adequate description of homecare information system plans and electronic data exchange activities. Agency adequately describes ability to participate in electronic data exchange with KIDSNET, required enhancements, and timeframe enhancements.

- Agency provides adequate proposal for conversion to electronic data submission within 6-9 months

2. *Community Coordination and Partnerships*.....0-20____

- Applicant has broad network of partners and experience working within local communities
- Applicant has adequate linkages to local agencies that provide services specifically for children and families, such as pediatricians, human service agencies, social service agencies, and child care
- Applicant has proposed creative plans for identifying and serving families who are at risk within the community, through local community coordination and referrals
- Applicant has included adequate plan for linkage and coordination with the pediatric health care community
- Agency has provided detailed plans which adequately demonstrate how they will carry out all activities which are required for coordination with each specific program outlined in this RFP
- Agency has provided detailed plans which adequately demonstrate how they will ensure that families connect with the agencies they are referred to and engage in services
- Agency has provided adequate letters of support from key community partners

3. *Outreach Activities* .....0-10____

- Applicant has developed a clear, adequate plan for outreach activities, including identifying and reaching families who have multiple risk factors, a follow-up plan for families who initially refuse a visit
- Applicant demonstrates adequate plan for coordinating outreach activities with other community agencies to identify families, such as EI, WIC, DHS field offices

4. *Budget*.....0-20____

- Business plan is realistic and reasonable, maximizes resources, and includes a detailed plan for potential home visit volume to support current or anticipated expenses and existing staff.
- Business Plan includes projected caseload and projected number of visits by personnel type (Nurse, Social Worker, Paraprofessional) and by funding type, (HEALTH or Medicaid) including Medicaid denials
- Policies, procedures and experience in 3rd party liability and Medicaid reimbursement are assured.

Total .....0-100____

Appendix A

Criteria for Referral to the Family Outreach Program From Level I Screening

Criteria for Referral include:

Any 1 of the following:

- Developmental Disabilities and certain other established conditions
- Birth weights less than 1500 grams (3.3 lbs)
- Neonatal Intensive Care hospitalization greater than 48 hours
- Mother is Hepatitis B surface antigen positive

Any 2 of the following:

- Caregiver's education less than 11th grade
- Mother's age less than 19 or greater than 37
- Single Caregiver
- Mother's number of live births greater than 5
- No previous live birth to mother
- One parent characteristic (e.g. chronic illness)
- Less than 6 prenatal care visits before 36 weeks, or total number of prenatal visits less than 10
- No prenatal care visits before 5 months
- Gestational age greater than 37 weeks and birth weight 1500-2500 grams (3.3 - 5.5 lbs.)
- Apgars at 1 and 5 minutes less than 7
- Medicaid/RIte Care

Clinical Information is also factored into the determination.

Appendix B: Screening Tools

Required Screening Tools for Home Visits

Initial Home Visits

- **Family Assessment:** Rhode Island Department of Health Family Assessment
- **Child Assessment:** Infant Profile or another assessment to be determined and approved by HEALTH

Level 2 Home Visits

- **Child Developmental Assessment**: Ages and Stages Questionnaire, by Bricker, Squires and Mounts

CAPTA Visits

- **Child Developmental Assessment**: Ages and Stages Questionnaire, by Bricker, Squires and Mounts

Optional Screening Tools for Home Visits

- **Family Resources Assessment:** Family Resource Scale, by Leet and Dunst
- **Family Support Assessment :** the Family Support Scale, by Dunst, Jenkins and Trivet
- **Home Assessment:** HOME Inventory for Families of Infants and Toddlers, by Caldwell and Bradley

Copies of these assessments can be requested from the Department of Health by contacting Theresa Hancock at 222-4308.

Appendix C: Budget Summary

Family Outreach Program Budget Summary for RFP Responses

Estimated Annual Budget

Medicaid Fee For Service

	Number	Rate	Total
RN Visits		$104.95	
SW Visits		$84	
Paraprofessional Visits		$70	
Total			

HEALTH Fee for Service

	Number	Rate	Total
RN Visits		$99	
SW Visits		$84	
Paraprofessional Visits		$70	
Total			

All Visits

	Number	Total
Medicaid Fee For Service		
HEALTH Fee for Service		
Total		